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medical social services for children

in the maternal and child health and crippled children's programs

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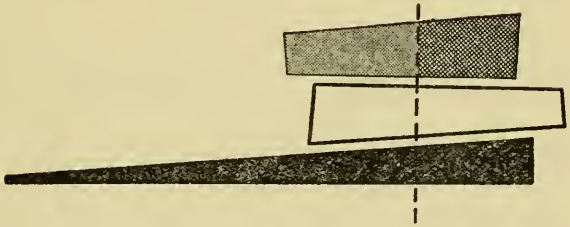

in the maternal and child health and crippled children's programs

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foreword

My interest in medical social work goes back for a good many years. Having spent the year before I entered medical school as an apprentice medical social worker in the Massachusetts General Hospital, I had seen at first hand what the vision of that great pioneer, Dr. Richard Cabot, had meant, in terms of the social component of medical care, to patients in the hospital. The impact of my contacts with Ida Cannon, chief of the social service department, and her staff carried over into the years of my medical training, hospital and teaching experience, community research, and advisory activities.

On looking back it is easy to see why, when I came to Washington in 1935 to administer the maternal and child health and crippled children's services established by the Social Security Act, that I knew it would not be possible to develop these programs effectively without consideration of the social aspects of medical care. For this reason I asked Edith Baker to join the Children's Bureau staff. I knew then—as I know now—that in addition to the medical, nursing, and related staff services, we needed a social focus in planning for and developing these health programs for mothers and children.

The early days of these programs were exciting days—days of long and animated discussion as to what and how programs should be set up, how teamwork among the health staff could be developed, how one group of social work interests—medical social work—could be related to another—child welfare work. These were days of exploring possibilities, days of questioning, days of refreshing advice and aid from people in many professions, days of great satisfaction as we saw functioning programs emerge from planning.

Medical social services were new both to the Children's Bureau and to the State agencies. At that time only two public health programs in the United States had medical social workers. Clearly this service had to prove itself in the public health setting —and must be of good quality. Civil service and merit system professional standards and qualifications had to be kept high. Medical social workers were needed not only to give consultation but also to demonstrate the social casework services required by

the mothers and children in these health programs. For these reasons, as this publication shows, the medical social work section was first attached to the crippled children's program. Later when the maternal and child health and crippled children's programs were brought together under one medical administrator, the medical social work section also officially served both programs.

Through the years, the Children's Bureau and the health agencies have learned that medical social work helped us to look more closely at ways in which services could be directed to meet the needs of people, to see how policies of administration or practice could further—or hinder—the use of services. Much of the merit of the contribution of medical social workers lies in the fact that they so effectively and unobtrusively merge it into the contributions of all the members of the professional team. And those of us who have worked with them through the years know that they kept us all looking at mothers and children as individuals.

From the first the Children's Bureau saw the importance of working closely with schools of social work offering medical social training. Students needed to know what we were learning about medical social practice in a public health setting whether or not they were to work directly in these programs or cooperate with them. In 1945, Doris Siegel came to the Bureau to give direction to this whole development, to look at practice for its implications for education and at education to see that it was firmly grounded in practice.

At the time medical social work was introduced into the Children's Bureau, workers in the field had already established the custom of evaluating their own practice—and the education on which it was based. This had been done periodically in relation to medical social work in hospitals.

Many of the early studies of medical social work were milestones in social work—milestones carefully marked by such pioneers as Janet Thornton and Harriett Bartlett. Miss Bartlett in her introduction to one of these studies said that "Although the changing situation as the years pass will undoubtedly mean that much of what is here set forth will be outgrown, experience shows that the basic idea in each study proves enduring." It is out of such devotion to progress as this that growth occurs.

In this publication medical social work again evaluates itself, this time in terms of the functions carried by medical social workers in the maternal and child health and crippled children's services under the Social Security Act. Much of this material grew out of a meeting called by the Bureau in June 1951 to analyze medical social practice in these programs. In the Bureau's planning for this meeting, Miss Bartlett, who had been responsible for

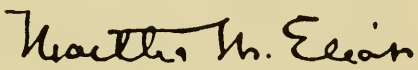
two of the early studies, and Miss Baker, a member of two of these early committees, served as a link between previous evaluative efforts and the one recorded here.

This meeting looked at practice as developed in these programs, its validity and its strengths, its soundness as a base on which medical social education could be planned and, if need be, modified. The meeting was founded on the conviction that the only people who could take this look were the people who were doing the job.

During the first 3 days of the meeting, State and local medical social consultants representing maternal and child health and crippled children's programs in 16 States and the medical social staff of the Bureau met under the chairmanship of Miss Bartlett. Medical social representatives of the professional organization, education, practice in hospitals, and the Public Health Service joined them for the final 3 days.

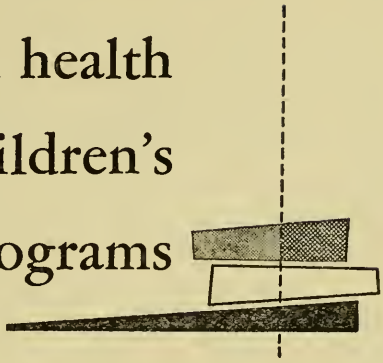
This publication is one of the tangible outcomes of this pooling of experience. It will be of interest to medical social workers in these programs, in hospitals, and in other organizations cooperating with them. Those responsible for educational programs in this field will find much of interest in this publication, too. We also believe this publication can be used by public health administrators and other professional personnel in interpreting the contribution of medical social work to the care of mothers and children, both sick and well.

We hope—and believe—that this publication will spur medical social workers on in their traditional role of helping sick children and their parents— and indeed in the newer and less traditional role of work with families who are reached in the public health setting—with those social and emotional problems which so insidiously hamper the well-being of children.



MARTHA M. ELIOT, *Chief*
Children's Bureau

the maternal and child health and crippled children's programs



MEDICAL SOCIAL SERVICES first developed in connection with the practice of medicine in hospitals. These services were gradually extended outside the hospital into various health, welfare, and related organizations, both public and private. The passage of the Social Security Act providing for programs of maternal and child health and crippled children's services speeded up this process.

In planning for these programs the Children's Bureau had foreseen that mothers and children seeking these services would have social and emotional problems relating to health and illness. As State programs were planned and set up, State agencies, too, came to this conclusion. For this reason, medical social workers were added to the staffs of these agencies to provide the skilled social services that parents and children required to meet these problems. In spite of shortages in the professional field, this development has continued steadily until at the present time almost all State crippled children's programs and a growing number of maternal and child health programs employ such workers.

Description of the Programs

A brief description of the programs will serve as a background for understanding the medical social services in them.

Maternal and child health services

Under Title V, part 1 of the Social Security Act, funds are authorized to be administered by the Children's Bureau and granted to the States, "for the purpose of enabling each State to

extend and improve as far as practicable under the conditions in such State services for promoting the health of mothers and children, especially in rural areas and in areas suffering from severe economic distress * * *." The Act designates the State health department as the administrative agency in each State. As a result divisions of maternal and child health with responsibility for organizing and developing programs to carry out the purpose described in the Act have been established in every State health department. As organized local health departments have developed, the responsibility for administration of services has been delegated to them.

Maternal and child health services in this program are defined as the protection, promotion, and conservation of mental and physical health of children from the prenatal period through adolescence and of their mothers through the reproductive cycle. A variety of services are included in the program. Among these are maternity clinics, child health conferences, pediatric clinics, health services for school-age children, dental, public health nursing, nutrition, and medical social services. Increasing attention is being given to the mental health aspects of the program. In addition to these services, funds under the maternal and child health program are used for in-service training and postgraduate education of the professional workers represented on the health team.

State agencies frequently emphasize certain services under the program. Some States direct much attention to prematurity, the largest single cause of infant deaths. They not only provide physician's services and hospital care, but they also furnish special equipment such as incubators and arrange for specialized training of personnel. A few States provide medical and hospital care for some mothers who have complications of pregnancy. Other States bring specialized obstetrical and pediatric consultation to many rural areas. Most States furnish consultation to hospitals on their services and facilities for mothers and children.

Crippled children's services

Title V, part 2 of the Social Security Act authorizes funds to be allotted by the Children's Bureau to the States "for the purpose of enabling each State to extend and improve (especially in rural areas and in areas suffering from severe economic distress) as far as practicable under the conditions in such State, services for locating crippled children, and providing medical, surgical, corrective and other services and care, and facilities for diagnosis, hospitalization, and aftercare for children who are crippled or who are suffering from conditions which lead to crippling."

The act does not designate the State agency to administer the program. Health departments are responsible for administration of the services under the program in 33 States and Territories; State departments of public welfare, medical schools of State universities, State departments of education, and State commissions carry such responsibilities in the other States. In most States, the administrative responsibility is carried centrally with State personnel serving directly in local communities. In a few States, where the administrative agency has local counterparts, this responsibility is being more and more decentralized.

In order to carry out the purposes of the Act, the State program tries to encompass a statewide network of interrelated services and facilities, but variation, of course, exists. In general all States carry on active case-finding, attempting in various ways to locate early the children who need care. All States hold or arrange for clinics throughout the State. These may be permanent clinics or itinerant clinics held at intervals in a community. Diagnostic services including the necessary procedures are made available to all children. Children accepted for care are given the full range of services available under the program.

Because the care of children with crippling conditions is complex, the skills of many kinds of professional personnel are required. The services of physicians, public health nurses, medical social workers, physical therapists, nutritionists, and others are made available to children needing them. All these workers are concerned not only with the physical condition of the child, but with what is happening to his social and emotional development.

The Social Security Act does not define "crippling condition." Each State has either a legal or an administrative definition. From the beginning the State programs accepted handicapped children who needed orthopedic or plastic treatment.

As additional funds have become available, States have interpreted "crippling conditions" more broadly. More than half the States are now accepting children with rheumatic fever, but most of them limit geographic coverage to an area in which adequate services and facilities can be provided. A number of States offer special services for the child with cerebral palsy. Still others include children with impairment of hearing or vision and epilepsy in their program.

Requirements of the Programs

The State agency responsible for the administration of the maternal and child health and crippled children's programs submits a plan to the Children's Bureau describing the needs of these

groups of mothers and children and how it intends to meet them.

The way the States draw up their plans varies considerably. Each plan, however, has to meet certain basic requirements set down in the Social Security Act. These are: Financial participation by the State, administration of the plan or supervision of administration by the State agency, methods of administration essential to proper and efficient operation, the submission of reports, carrying out the purposes of the act, cooperation with medical, health, nursing, and welfare organizations and other groups. For the crippled children's program, cooperation with vocational rehabilitation agencies is also specified; for the maternal and child health program, a demonstration is required. The development of this plan provides State staff with an opportunity for joint thinking.

In addition, the Children's Bureau issues regulations [1] that have the effect of law. These include such requirements as: Medical direction for maternal and child health and crippled children's programs, a plan for informing the public throughout a State as to the services under the programs, all information as to personal facts and circumstances of patients to constitute privileged communications and to be held confidential, freely available diagnostic service under the crippled children's program.

Appropriations for both programs are divided into two separate funds, one requiring matching by the States; the other granted without matching. Part of this latter fund is reserved by the Children's Bureau to be allocated for special projects of national or regional significance such as training programs.

Federal-State Cooperation

In the development of maternal and child health and crippled children's programs, the States and the Children's Bureau each have a definite role. The States, with responsibility for administration of services, and the Children's Bureau, with responsibility for granting funds to extend and improve services, work closely together.

Staff members of State programs are acutely aware of many problems arising out of the administration of the programs. They see what certain gaps in service mean to people. They recognize the effect of certain policies in either hindering or facilitating care. Often they bring these problems to the attention of the

[1] Part 12–4. Regulations for maternal and child health and crippled children's programs. PHS–CB Health Grants Manual, Federal Register, June 28, 1949.

Children's Bureau and then work with the Bureau in bringing about changes. But in the final analysis, it is the States who know needs best and who must develop the means for meeting them.

As a Federal agency, the Children's Bureau is in a position to study and observe programs in all the States, to keep abreast of current knowledge on matters relating to child health, and to collect facts about new methods of treatment and of developing services. In arriving at many of these ideas, the Bureau seeks the help of advisory committees made up of outstanding leaders in various fields. Recommendations of these committees are made available to all States.

The Bureau also holds conferences where workers from both public and private agencies can exchange ideas and experiences. It works with many universities and schools, bringing to them a nationwide picture of the needs of health workers for education and training. The most significant contribution made by the Bureau, however, has been in the consultation services which it offers to States through regional teams composed of pediatricians, nurses with pediatric or maternity training, medical social workers, nutritionists, and administrative methods consultants.

Thus the States, because they are closer to the people served, contribute the realities of practice; the Bureau, because it has an opportunity to learn about developments in many States, contributes a broad perspective.

Some Basic Concepts

Out of this joint consideration by the States and the Children's Bureau, certain concepts underlying the administration of maternal and child health and crippled children's programs have emerged. Any understanding of the programs as a setting for medical social work involves an understanding of these concepts.

The belief that people have a right to know about services available through public agencies is one of these concepts—a concept incorporated in the regulation requiring that services be made known to the people. States have found that such information is essential, not only for those families who seek care for their child, but also is helpful in enlisting community support and interest in locating crippled children. The importance of adequate case-finding has been fully demonstrated by the States. For example, the early discovery of a crippled child often has a direct bearing upon whether his condition can be corrected with little or no residual handicap or whether it can only be alleviated.

Similarly early prenatal care may help assure a healthy mother and baby.

Another concept is that diagnostic services should be readily available to all children in the crippled children's program. This is embodied in the regulation of the Children's Bureau: that diagnostic services will be made available within the area served by each diagnostic center to any child, without charge, without restriction as to the economic status of the child's family or relatives, or their legal residence, and without requirement for the referral of the child by any particular individual or agency. The eligibility of a child for treatment can only be decided after his needs are diagnosed.

This concept was reinforced and elaborated by an advisory committee of the Children's Bureau in its recommendation: "One of the most fundamental of human rights is the right of every individual to the maximum degree of physical and emotional health which it is possible for that individual to attain with the aid of the best scientific knowledge and technical services which are at the disposal of the Nation. The knowledge and services which deal primarily with the prevention of disease, promotion of health in a positive sense, and the detection of incipient disease form a part of the basic community health program." [2]

The advisory committee, having commented on diagnostic and preventive services went on to say that "the treatment of disease is a problem of a somewhat different nature, although still a problem much more clearly related to public health than to poor relief." Where, however, the funds for service of this kind are inadequate for universal coverage, "preference should be given to those most in need."

In practice, States are determining eligibility for service in accordance with economic as well as medical need. For example, services in the child health conferences are being made available to mothers and children in the lower economic groups primarily. The crippled children's programs take into account the nature of the crippling condition, the type and amount of medical and surgical care required, the availability of other resources, and the estimated cost of providing care as well as the family's income and obligations.

Another concept stated by the advisory committee emphasized that "they [children] should be treated as children, not as

[2] Recommendations of the Children's Bureau Advisory Committee on Maternal and Child Health Services, in Annual Meeting of the Children's Bureau Advisory Committees on Maternal and Child Health and on Services for Crippled Children, Children's Bureau, September 16 and 17, 1946. 19 pp. (p. 17) (mimeographed).

disease entities or handicaps." [3] This applies with equal force to all patients—young and old alike. Experience has clearly demonstrated that an individual approach to the patient and his family is essential. Social, emotional, economic, and environmental factors must be considered along with physical factors. Operating on this concept, the programs are increasingly providing medical social services as a basic part of a broad program of health and medical care. Because of the emphasis on psychosocial factors in these programs and the broad scope of the services in them, they have presented a rich opportunity for the development of medical social work.

The importance of treating the individual with respect and with feeling for his dignity and worth as a human being is constantly stressed in these programs. Policies are seen, not as regulations to limit a program, but as means to help carry out its purposes. Procedures are seen not as a set of instructions but as ways of helping people get what they need while safeguarding their self-respect and initiative.

The maintenance of parent-child relationships, during periods of enforced separation when hospitalization of the child is necessary, is a matter of genuine concern in planning for the care of individual children in these programs. Often children at such times are fearful and feel deserted by their families. This not only retards their recovery, but may also be reflected in emotional difficulties later on in their lives.

Parents are being helped to prepare children for this hospital experience. More and more the State programs are making it possible for parents to visit their children while in the hospital. Hospitals, in turn, are giving parents more opportunities to participate in the care of their children. Sometimes States use funds to pay transportation of parents to hospitals or enlist assistance from other agencies.

All children need educational opportunities—this is equally true of the child away from home in the hospital or convalescent home and the child in his own home deprived of schooling because of his illness. Consequently, State agencies are working with State and local departments of education in providing these opportunities for children under the programs. Some hospitals are also developing recreational activities and, in a few instances, social group work.

Individual children frequently need social casework help with difficulties created or enhanced by hospitalization. Through

[3] Recommendations of the Children's Bureau Advisory Committee on Services for Crippled Children, 1935–1946 (meeting held December 7–8, 1944 at the Children's Bureau.) 23 pp. (p. 17) (mimeographed).

consultation to hospitals without social service departments, State agencies are pointing out that such difficulties may interfere with the child's adjustment in the hospital and with his progress toward recovery. They are advising hospitals to establish social service departments wherever possible, and pending such service, suggesting ways in which social resources in the community may be used.

State agencies are emphasizing the importance of good planning for discharge from hospital care; they are stressing the desirability for the child's return to his own home, recognizing its value for his emotional growth. When a child's home is not or cannot be made suitable for aftercare, children are being transferred from hospitals to the more homelike environment of the convalescent home. In cooperation with the child welfare divisions of State welfare departments and private children's agencies, many States are working out plans for care in foster homes for those children whose emotional needs make group care undesirable, where convalescent homes do not exist, or when boarding care near a medical center is needed.

When a child returns home, State programs are continuing to operate on the same concept of individualized service to help him reach maximum functioning. Continued clinic care and the services of the health team are provided as needed. Child welfare services are frequently used in giving certain social services. Plans for vocational guidance to many adolescents are worked out with vocational rehabilitation agencies. More and more selective referral for such service is used. Both agencies recognize that some adolescents may be emotionally ready to face their handicaps and to think about the need for special training and employment. Others are unable to accept the fact that they have a permanent handicap and consequently cannot make the best use of retraining without social casework help.

The concept of teamwork grew up early in these programs because State agencies recognized that the needs of mothers and children could not be met by any one professional group, that various professional personnel had important contributions to make. The persons providing care had to become welded into a team before mothers and children would receive maximum benefit from this pooling of knowledge. Personnel in the States implemented this concept by joint writing of State plans, by staff meetings, by post-clinic conferences. Children's Bureau staff, organized on a regional basis with a regional team, have carried forward this same concept in their working relationship, staff meetings, and joint visits to States.

Cooperation with other agencies is a logical concomitant of the concept of teamwork. The Social Security Act actually

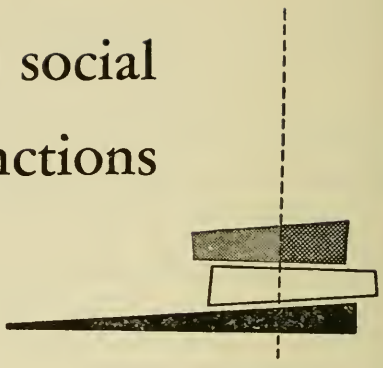
requires that State plans provide for "cooperation with medical, nursing, and welfare groups and organizations." States have tried to make this a living reality.

In all aspects of both programs, the concept of quality of care has been emphasized. Very early in the programs, the Bureau working in conjunction with various professional groups recommended standards for all types of personnel needed in the care of mothers and children. The Bureau recognized that medical social work because it was new to these programs would have to prove itself and took leadership in supporting high qualifications for these workers. The Bureau recommended that medical social personnel should have completed professional education and have had supervised experience in a social service department of a hospital. The 1939 amendment of the Social Security Act required appointment under a merit system of all full-time personnel, and gave the Bureau an opportunity to work with the States in developing standards to be set by the States which would protect the quality of service. Advisory committees of the Bureau also recommended standards for facilities to be used in providing services. The State agencies have also developed additional standards. Various other methods of improving quality of care are being devised and carried out.

Quality of care cannot be achieved without continuity of care. State agencies recognize that information about individual mothers and children must flow from doctor to doctor, from one professional worker to another, from facility to facility, from facility to home and community if planning is to be done on a sustained basis and if future service is to be based on the care already given.

Today maternal and child health and crippled children's programs are attempting to provide the full range of services that go into adequate health and medical care. Conditions in each State and the stage of the development of its programs create differences in approach. However, in various ways States are working toward promotion of health, reduction of maternal and infant mortality, prevention of disease and disability, treatment of illness, correction of defects, and rehabilitation. All of these contribute to the objective of "extending and improving" services for mothers and children.

medical social functions



The fields of public health, medicine, and social work are in a state of flux. This moving, fluid state is good and out of it is coming better health and social services for mothers and children. Programs are changing and growing—and it is for this reason that all the health and social work professions are examining and clarifying their functions.

The primary functions of medical social work as outlined below may entail different emphases and proportions of time on the part of the worker. They all are based on the same social philosophy and require an understanding of the individual, of the dynamics of behavior, and of social relationships. They require skill in special ways of working with people. The functions themselves are interdependent and component parts of a job; they are not separate and isolated. One grows from and is strengthened by the other. Each flows naturally into the other.

The basic objective of the professional team in maternal and child health and crippled children's programs is better service to individuals. The medical social worker in achieving this objective uses two channels: (1) giving service to individuals directly and (2) working with others in strengthening services given through the programs.

Analysis of Functions

The following are characteristic functions of medical social work—and they will serve as a framework for the analysis in this section.

1. Services to individuals.

   Social casework service.
   Consultation to other professional workers.

2. **Program planning, policy making, and standard setting.**
   Direct participation.
   Consultation with others.
3. **Community planning.**
   Direct participation.
   Consultation with others.
4. **Educational activities.**
   Direct education of the various disciplines.
   Consultation with others.
5. **Studies, surveys, and research.**
   Planning and carrying out of medical social studies and surveys.
   Participation in studies, surveys, and research in other fields.
   Consultation with others.

In addition to these functions, medical social work, of course, includes administrative responsibilities in planning and directing social services.

Services to individuals

Both facets of services to individuals—social casework service given directly and consultation services given to others—are intimately interrelated. Both are important and integral parts of the care given to patients under the maternal and child health and crippled children's programs. Social casework services constitute a base for the medical social worker's consultation. Such consultation, in turn, leads to a greater recognition of the need of people for social casework services. Each aspect thus strengthens the other.

Social casework service.—Social casework service in these programs as in the hospital is concerned with problems which affect health, grow out of illness, or interfere with attaining maximum benefits from health services and medical care. Social casework is usually given at places where the mother or child comes for care: The clinic, the hospital, the convalescent home—or in their own home.

By their very nature, these programs present certain special problems in terms of social casework service. For example, itinerant clinics for the medical social worker, as for other members of the staff, mean going into a community to work for only a brief period. This calls for skill in establishing a relationship with the patient, in evaluating the situation, in ascertaining the kind of help needed, and in giving this help as creatively as possible—all within a time limit. It also calls for skill in working with local personnel

and with community groups. Often these clinics are held in rural areas where resources are limited and problems not easily met.

In the following case, paragraphs dealing with the process are in bold type. One State medical social worker tells about the casework help given to a girl seen in the clinic because of the possibility of epilepsy.

A 17-year-old girl, Anne, came to an epilepsy clinic because her family doctor thought that her history of recent seizures suggested the possibility of epilepsy. In order to make a definite diagnosis, the doctor at the clinic recommended that she have an electroencephalogram. Anne refused. Her mother, who accompanied her to the clinic, seemed distraught and upset, but offered no objections to Anne's refusal.

The situation

At this point, the doctor suggested that they talk with Mrs. Barton, the medical social worker. Perhaps she could help them. Anne said she didn't know how anyone could really help her. One thing was certain, she added, no one could persuade her to do what the doctor advised. She wouldn't change her mind.

The casework interview

Believing that Anne, like most adolescent girls, wanted to be treated like a responsible adult, the worker proposed that Anne come into her office alone, and that a little later, her mother might come in.

Anne came in slowly. During the interview, she sat rigidly on the edge of her chair as though she might bolt out of the door at any second. She told Mrs. Barton that she did not have epilepsy, that she saw no reason to talk over anything, that she was in a hurry and wanted to go home.

The worker realizing that Anne was very upset, tried to encourage Anne to express her feelings. She said that she appreciated that Anne was having a hard time, was angry about everything that had happened to her.

Anne agreed explosively, expressing her resentment about the doctor, the clinic, and her mother for bringing her to it.

The worker believed that Anne's anger might be a sign of her fear of the diagnosis of epilepsy—a fear that Anne did not recognize or at least admit even to herself. The worker thinking that Anne might obtain some relief by talking about what was really troubling her tried to draw Anne out by asking her whether she was angry at the possibility of epilepsy, too.

Anne hesitated a moment, then admitted she was mad about that, too. Mrs. Barton said people are often upset about seizures. At this point, Anne began to talk more freely. She told of her embarrassment over the seizures, her feeling of being different, her fear that she would not be able to finish school if she had epilepsy.

The worker felt that at this point Anne might gain some reassurance if she were given some factual information.

Mrs. Barton pointed out that the doctor did not know for sure

whether Anne had epilepsy or not. The electroencephalogram would help him determine this. In most cases seizures can be controlled by drugs. Many drugs are used for this purpose and people are able to live normal lives. Although Anne sat silently during this discussion, she seemed to be growing less tense.

The worker knew that most adolescents face problems of social and emotional adjustment in the normal process of growing up, and that the possibility of epilepsy would present a particularly difficult problem for an adolescent to face. Because of this, she continued to encourage Anne to express her feelings.

Mrs. Barton asked what else about epilepsy worried her? Anne struggled to control herself, but finally described almost wistfully, but with much determination, her desire to live a normal life, to have a family of her own, and to be independent rather than a burden on her parents. Hesitantly, she added that she was afraid she would lose her boy friend if he learned that she had epilepsy.

It seemed to the worker that Anne's wishes for herself represented the normal striving of an adolescent for maturity. Her reactions to the possible diagnosis of epilepsy were also natural and to be expected. She seemed to be asking primarily whether the attitude of others toward her would change because of her seizures.

For this reason Mrs. Barton commented that Anne had not really changed completely in the last hour, and just in the same way other people's feelings about her would not change. Even if a diagnosis of epilepsy were made, this was a medical problem, and did not represent a complete change in Anne as a person or in other people's feelings about her.

Anne became much more relaxed. Hesitantly, she said maybe Mrs. Barton was right, maybe if epilepsy were like other illnesses, she should follow the doctor's suggestion and have the electroencephalogram. Although the idea still seemed unpleasant and frightening to her, perhaps she could face it. Would Mrs. Barton be there when she came for it?

The worker recognized that Anne was beginning to trust her and to depend upon her for support. Perhaps here was the beginning of a relationship through which she might help Anne.

Mrs. Barton reassured Anne that she would be present at the clinic and would see her the next time she came. Anne said with a rush of confidence that she was sure she could go through with the electroencephalogram if she had the backing and support of Mrs. Barton.

As the interview ended, Anne's mother joined Anne and the worker. She seemed relieved at Anne's easier manner and her decision to follow medical recommendations. Anne's fear and upset over the possibility of epilepsy had almost overwhelmed her, too. Especially now that they knew that in many instances epilepsy could be controlled, they'd be able to do what the doctor recommended.

The example shows the worker beginning her help to Anne. She would, of course, have many interviews with her in a continuing casework relationship.

Social casework is a qualitative service which requires

skilled study, diagnosis, and treatment. The extent to which this service can be offered depends upon the number of qualified personnel in the program. The medical social worker in planning his individual job also must recognize that the essential nature of social casework limits the number of individuals to whom he can give this qualitative service. This principle applies whether social casework is given at the State, district, or local level.

Consultation to other professional workers.—The medical social worker's consultation to other members of the health team deals with problems arising out of the interrelatedness of the individual's social situation and his health and medical care. They include such problems as: Resistance to medical recommendations, such as admission to the hospital; return to the clinic; advice to limit activity; discharge against advice from a hospital; mother's guilt reactions to the child's congenital defect; emotional problems associated with such conditions as stuttering; marital problems and friction affecting family health; unreadiness to face pregnancy; inadequate finances for maintaining a decent standard of living or meeting the costs of medical care.

Consultation to other social workers outside the health agency is directed toward helping them give more effective casework service through increased awareness of the social and emotional aspects of health and illness and the way these factors influence the services they are giving.

One State medical social worker reports consultation with a child welfare worker and her supervisor:

> Jimmie, age 7, and his mother had been living alone since his father deserted 6 months ago. The child had been hospitalized for rheumatic fever and had returned home recently to convalesce under the care of a private doctor.
>
> Miss Pullen, the child's teacher, had stopped in to see him. She found a very unhappy, apathetic little boy—a marked contrast to the alert, responsive child she had known in school. The mother seemed so worried and distraught that the teacher had suggested that perhaps Miss Fischer, the child welfare worker, could help. The next day the mother called Miss Fischer at her office.
>
> After a couple of visits in the home, Miss Fischer asked Miss Jackson, her supervisor, for a conference to discuss this family. She said that the whereabouts of the father are not known. The family is living on a small income from property left by the maternal grandmother. The doctor had recommended bed rest for the child and the mother had interpreted this to mean complete inactivity.
>
> Miss Fischer expressed uneasiness about her help to the family. Jimmie seems so listless—takes no interest in anything and just lies in bed all day. He seems fearful and withdrawn. Does rheumatic fever affect children this way? Also, the mother hovers over Jimmie and seems afraid to allow him to do anything for himself. Apparently she had been very upset by the child's hospitalization. Miss Fischer hesi-

tates to offer suggestions or do anything in this situation because she knows so little about the effects of rheumatic fever. She is planning on talking to the doctor, but hasn't succeeded in reaching him as yet.

Miss Jackson thought that Miss Fischer had raised some good questions. Mrs. Irving, the State medical social worker, was coming to the county next week for the regular crippled children's clinic. Probably she could give them more understanding of the social and emotional implications of this illness so that they could be of more help to Jimmie and his mother in relation to his illness.

The consultation interview

An appointment was arranged with Mrs. Irving, the medical social worker. Miss Fischer told her about the situation in the home, and her questions about the cause of Jimmie's apathetic attitude. Does this always occur in children with rheumatic fever?

The medical social worker realized that a clear picture of the medical situation was essential before the implications could be understood. For this reason, Mrs. Irving suggested that they first consider the medical recommendations. Of course, Miss Fischer knew certain general things about rheumatic fever, but what she needed to know were certain specifics about the boy's condition. When she talks to the doctor, she would probably want to ask him about such things as how long the boy would be convalescing, when he could begin activity, how much and what kind, what the prognosis was, and how often the doctor would want to see Jimmie. Once they had this information, Miss Fischer would be able to plan with the mother on a sound basis.

Miss Fischer thought that she could use these suggestions in talking with the doctor. Although she had worked with doctors often in the past, she hadn't realized that her questions should be focused so clearly. Maybe, she said ruefully, that was why she hadn't gotten useful answers from doctors on previous occasions.

Even before she talked with the doctor, Mrs. Irving thought Miss Fischer might want to know something about the meaning of long-term illness to a child. In her experience she has found that children react to a chronic illness like rheumatic fever in different ways. Some become overdependent and even complete invalids. Others are rebellious and overactive. Often these youngsters feel different from other children and this makes them even more insecure. Back of all these feelings may be a fear of death. Sometimes they think their illness is punishment for something they may have done or thought.

Jimmie seems to be reacting by listless dependency. Of course, it was to be expected that Jimmie revert to early patterns of behavior to some extent and a wish to be taken care of is natural in illness. But if this response to his illness continues, Miss Fischer may need to help him and his mother. How is Jimmie using his illness? How is he reacting to the restriction imposed by his mother? What satisfactions is he achieving through his illness? Does he seem fearful and overcautious? Has he always been an overly dependent child? Has the illness accentuated Jimmie's reaction to the loss of his father's companionship? What is the mother's part in this? Is she encouraging his dependency because of her own needs? Is her overconcern an expression of guilt feelings because she may basically reject Jimmie?

Miss Fischer said she did not know the answers to many of these

questions, and that she would need to know them before she could help Jimmie a great deal. The mother was certainly making him dependent upon her, insisting on doing everything for him. Miss Jackson thought possibly the fact that the father had deserted the family had made the mother turn to Jimmie for most of her satisfactions.

The medical social worker suggested that as Miss Fischer grew to know the boy better, she would have a clearer understanding of what this illness is meaning to him and how he is using it. This would indicate how Miss Fischer might be helpful. For example, if the doctor approved, Jimmie could be encouraged to take small responsibilities, even though these might need to be started slowly. Miss Jackson commented that he and his mother would need real help from Miss Fischer if this process was to be tried. The medical social worker wondered whether some diversion would help Jimmie? Could Miss Fischer suggest to the mother that the mother talk to Jimmie's teacher, Miss Pullen, about having his playmates come to see him? Does he have any playmates he would particularly like to see? Of course before she did this, she would want to find out from the doctor whether he could have visitors, how often and how many.

Miss Fischer added that Jimmie seems like a bright little boy and she understands from Miss Pullen that he had done well in school. If he has to stay home for a long period of time, perhaps a home teacher could come in to keep him up with his school mates.

Mrs. Irving said so far they had concentrated mainly on the child. But she knew that Miss Fischer was concerned about the mother, too, since her relationship with Jimmie properly managed, might become the most potent force in his recovery. She pointed out that parents react in many ways to the illness of a child. They have fears, too. Often parents feel guilty and even blame themselves for something they may have done or thought in relation to the child. What is the mother's understanding of the illness? Does she have some misunderstanding of its causes that makes her feel unduly responsible?

Miss Jackson commented the mother might be resentful about the additional responsibilities placed on her by Jimmie's illness. On the other hand she may feel that she has not done enough for him, and that she has in some way deprived him of his father. Any or all of these feelings might result in oversolicitude.

Mrs. Irving thought that all these possibilities should be considered. She added that the mother may have had high hopes for Jimmie's future and now sees that they may be blasted.

Mrs. Irving said that the mother should be encouraged to talk over her worries about Jimmie's illness and her possible fears of a recurrence and the development of serious heart damage. She needs help in understanding what Jimmie may be feeling and how she can sustain him during the coming months. Perhaps she can be helped to find outside interests for herself. Perhaps someone can be found to look out for Jimmie occasionally. These possibilities might be explored.

Both Miss Fischer, the worker, and Miss Jackson, the supervisor, said that the conference had been most helpful. Mrs. Irving stated that she would be interested in learning about the progress they made with Jimmie and his mother. Miss Jackson assured her that they would keep her informed. Perhaps they would need further help at a later date and would want to see her.

In this situation, the medical social worker not only dealt with the quesions presented by the child welfare worker, but attempted to inject new ideas for her consideration. Because of the medical social worker's knowledge of the interrelationship of the medical and social factors, she was able to add to the child welfare worker's understanding of and approach to this family.

Another State medical social worker describes consultation with a public health nurse and her supervisor as follows:

> Mrs. Harris, a small, attractive young woman of 22, had come to the prenatal clinic held in the local health department about 2 months ago when she was 4 months pregnant. This was a first pregnancy, occuring soon after her marriage. The doctor had examined Mrs. Harris and found her in good condition, despite her complaints of numerous aches and pains. He had explained to her the importance of returning to the clinic for regular medical supervision but had told her if she didn't feel well to come at anytime.
>
> The staff nurse, Miss Aiken, had then seen her in a nursing conference and talked with her about her care during pregnancy, about plans for delivery and for the coming baby. Mrs. Harris said that she had never dreamed she would have to come to a public clinic or be delivered in the county hospital. She said with some shame that she had always expected to go to a private doctor but her financial circumstances did not permit this. Miss Aiken had reassured her and had thought Mrs. Harris understood she was to return to the clinic the following month.
>
> When Mrs. Harris failed to return on the appointed date, the nurse made a home visit. She found Mrs. Harris upset. Mrs. Harris told the nurse she and her husband had recently moved into this room in a boarding house from her mother-in-law's home. Her husband was working intermittently as a laborer at a very small wage. She hadn't come to clinic because she just hadn't had money for car fare. She wasn't eating well and everything seemed just too difficult. Miss Aiken had asked whether she had ever thought about going to the Department of Public Welfare for help, but Mrs. Harris had recoiled at the idea. Miss Aiken thought Mrs. Harris seemed more relaxed after talking awhile. She agreed to come to the clinic next week.
>
> Again, however, Mrs. Harris did not come. When Miss Aiken made another home visit, Mrs. Harris said she had not come to the clinic because she was not feeling well. She would show up the next week. Again Mrs. Harris failed to come to the clinic. Miss Aiken told the doctor about her home visits and her efforts to encourage Mrs. Harris to follow the recommendations which he had given her on her first visit. He urged the nurse to continue her efforts to get the patient back.
>
> Miss Aiken then brought the problem to her supervisor, Mrs. Gillett, for discussion and help. Miss Aiken realized she could not force Mrs. Harris to attend clinic, but she was concerned about her condition and about finding ways to help her. She was concerned, too, about how Mrs. Harris was managing to pay the rent, to buy food, and to get the necessary supplies for the baby.
>
> Mrs. Gillett agreed that it was important to get Mrs. Harris under medical care. Possibly Mrs. Harris' reasons for not coming had a real basis. Perhaps she had not had the car fare. Perhaps she hadn't

felt well. But, the fact that she had not returned over this long period of time might mean that there were underlying feelings that were keeping her from coming. Reasons patients give, she explained, are sometimes very different from a patient's real reasons. Would it help to discuss this situation with Mrs. Davenport, the medical social worker in the department? There are things about Mrs. Harris' situation we don't understand. Perhaps Mrs. Davenport can help us with them.

The consultation interview

When Miss Aiken and Mrs. Gillett came to see Mrs. Davenport, Miss Aiken described the situation and her concern about Mrs. Harris' failure to come for medical care. Mrs. Gillett added that they felt that possibly Mrs. Harris was really resisting medical care and that she had certain feelings they needed to understand in order to help her.

Mrs. Davenport agreed that Mrs. Harris' behavior might indicate some feelings that had nothing to do with finances—feelings that were interfering with her continuing with medical care. Sometimes such resistance masks a real fear of pregnancy. Sometimes it may mean a rejection of the pregnancy itself. It almost seems as if the woman, not wanting her baby, feels that by avoiding medical care, something will happen and she will not really have to have the baby. Perhaps the husband does not want her to have a baby either. Of course, such feelings may have a very realistic base such as her husband's intermittent work, the pressure of inadequate finances, living in one room, her loneliness.

Actually, they didn't really know whether any of this would apply to Mrs. Harris but these possibilities should be kept in mind. Had Mrs. Harris mentioned her husband's family at all? Had she talked about his relationship to his family? How does he feel about her pregnancy? Did she discuss the coming baby and any plans she had made for him? Miss Aiken might be able to help Mrs. Harris express some of her feelings. Sometimes if patients are given an opportunity to express their feelings to an understanding person who listens and is not critical, they find it possible to take the next step.

Miss Aiken thought she might find some of these ideas useful. Did Mrs. Davenport have any suggestions regarding her discussion with Mrs. Harris about her financial situation? Miss Aiken would try to find out more about Mr. Harris and his work. In a number of situations, lately, she had found families who resisted applying for assistance even though they really needed it. Miss Aiken knows herself how difficult this would be for her to do. Yet if Mrs. Harris needs help badly, shouldn't she ask for it?

Mrs. Davenport said that they undoubtedly appreciated the tremendous emotional significance money has, and what is involved in seeking assistance. In our society, money is often a symbol of success, of power, of love. Lack of it often makes us feel we are failures, weak, unloved. If we have to ask for money, we are admitting all these things to ourselves.

Actually, of course, we do not know what meaning money has for Mrs. Harris, but her feeling about it may be tied up with other feelings. And certainly our own attitudes toward financial assistance often carry over to patients.

Could Miss Aiken talk with Mrs. Harris about the right of people to public relief if they have no other resources? We have over these

many years arrived at the feeling that it is no disgrace for people to receive assistance, because they have already contributed through taxes in this State as well as in many other States. None of this may, of course, apply to Mrs. Harris, but perhaps it would be worth exploring. Encouraging her to express her feelings might be good.

Miss Aiken and Mrs. Gillett thought these suggestions should be tried. The three of them would want to talk together again later.

The situation—three weeks later

Miss Aiken told her supervisor that Mrs. Harris had kept her last clinic appointment. The doctor had made a particular effort to tell Mrs. Harris how pleased he was to see that she had returned. He later told the nurse that he wished to keep careful track of Mrs. Harris because he was concerned about her attitude toward her pregnancy. Miss Aiken said that during her last home visit, Mrs. Harris had talked much more freely. She had obviously been crying a good deal and seemed lonely. She said that she had insisted that they leave the home of her husband's family, even though they didn't have enough money to consider getting an apartment. The room they are living in now is not far from her mother-in-law's home. Her husband is always there, stopping before he comes home. He seems more interested in his family than in her. Her family lives three hundred miles away, and she can't run to them. Her husband has worked more and more irregularly, and she doesn't know how they can keep on managing. Her family can't help them, nor could her husband's family—she wouldn't accept any help from them anyway.

Miss Aiken again broached the possibility of financial assistance, suggesting this is help they are entitled to if they need it. Mrs. Harris had said she and her husband would think about it. They would see.

Mrs. Harris kept saying with much feeling that her pregnancy had just come too soon. They should at least have waited until they had an apartment before she became pregnant. She hadn't made any preparation for the baby. Almost in passing she mentioned that "there are funny people in my husband's family"—a brother who was mentally ill and an aunt who was queer. She said with strong emotion that she would rather have her child born dead than turn out like her husband's brother. Miss Aiken said she had tried to reassure her about the unlikelihood of such a thing happening and had suggested that she discuss this with the doctor when she returned to clinic.

Mrs. Gillett agreed that Mrs. Harris was certainly having a difficult time. Even if she does apply for financial assistance, she still has many other worries: her feelings toward her husband, his uncertain income, her attitude toward his family, her early pregnancy, and her worry over her child's heredity. Mrs. Harris needs help now in facing some of these problems. The situation may grow worse and become even more complicated after the baby's birth. Miss Aiken said that the doctor had also been concerned about what might happen after the baby came. Mrs. Gillett suggested that Mrs. Harris might need some social casework help. They decided to talk to Mrs. Davenport again.

The consultation interview

Miss Aiken told Mrs. Davenport about her discussion with Mrs. Harris. Mrs. Gillett added that they both thought that in view of the deep feelings Mrs. Harris seems to have, maybe Mrs. Davenport should talk with her.

Mrs. Davenport said she would be glad to do this because she thought it was the kind of situation in which she might give some help. Apparently Mrs. Harris is deeply resentful of her husband's family and feels angry at their hold over him. She may feel they come first in his affections. She may resent the fact that he hasn't done well by her financially and believes he would have done better if he really loved her.

Miss Aiken agreed that Mrs. Harris was hostile to her in-laws. Mrs. Harris had said her husband wouldn't leave his mother at the time of their marriage and that was why they had moved in with her.

Mrs. Gillett wondered whether Mrs. Harris was not pretty mixed-up in her feelings about the coming child. Mrs. Davenport agreed with this. She may be rejecting pregnancy and what this might mean. She may be seeing the coming child as her in-laws' child, not hers. We would need to know more about Mrs. Harris as a person to find a clue to this—what had been her relationship to her own family, particularly her mother; how she had met other crucial situations in her life; what kind of attitudes had she brought to her marriage and what did it represent to her. There would be other things we would hope to learn about the husband in this situation, too—how he feels about the pregnancy, the coming child and becoming a father, and his relationship to his wife as he sees it.

Mrs. Davenport said that through social casework service she would try to help Mrs. Harris come to grips with the hostile, aggressive feelings that she seems to be denying even to herself. She hoped Mrs. Harris could be helped to be more accepting of herself as a person, to handle her fears and resentment, and to do something constructive about her situation. Mrs. Davenport explained that she would probably have to have many interviews with Mrs. Harris. People with difficulties as complex as those of Mrs. Harris usually need long, continuous and intensive help.

The group then considered what Miss Aiken might do to help Mrs. Harris see that she really should have skilled help with her attitudes and feelings, and that Mrs. Davenport might give this to her. She is so troubled and unhappy with her present situation that perhaps she would be eager for such help following the nurse's careful interpretation of what it might mean to her.

They agreed that Miss Aiken could be supportive to Mrs. Harris during the coming months, recognizing her problems, her fears, her feelings, her hostilities. The warm and sympathetic concern of the nurse would bolster Mrs. Harris many times. Since both the nurse and the medical social worker would be seeing Mrs. Harris, they would need to understand what each was attempting to do and to keep in close touch with each other.

The nurse and the medical social worker decided to talk all of this over with the doctor. The three of them would need to work closely together if Mrs. Harris is to achieve a good and happy solution to her many problems.

In this consultation, the medical social worker was able to distill out of her own experience with patients some of the meaning of their attitudes and actions. She went on to show what might be operating in this situation. Out of these discussions,

principles emerged that the nurses might find helpful in understanding other patients.

Program planning, policy making, standard setting

All members of the professional team in maternal and child health and crippled children's programs are concerned about social implications in program planning, policy making, and standard setting. The medical social worker's focus in these activities is:

1. To emphasize the scope of services essential for the individual if his social and emotional, as well as health and medical needs, are to be met.

2. To share information concerning the effect of current and proposed policies and procedures on children and their families and to promote reconsideration of them when necessary.

3. To consider the social aspects of standards set by the agency and to define standards for medical social services.

Program planning.—The content of the medical social worker's contribution to program planning is, of course, dependent upon the particular issue and situation. For example:

> A State health agency was considering the possibilities of developing a rheumatic fever program in a certain community. The medical director asked the nursing, medical social work, and nutrition staff to meet with him to discuss what services should be included in the program, how these might be set up, and how each professional group might contribute to them.
>
> Miss Douglas, the medical social consultant, suggested to Dr. Davis, the medical director, that it might be a good idea for her to talk to the welfare department workers prior to the meeting of the health department staff. From them she could secure some information about the social problems that they were finding in families in which there was a child with rheumatic fever. This was information that would be helpful in planning the program. To this plan, Dr. Davis agreed.
>
> The medical social consultant after clearing with the State welfare department asked the director of the county welfare department to arrange a meeting of his staff to discuss some of these problems.
>
> At this meeting the staff members of the welfare department described many problems they had encountered in working with the families and the children. These included difficulties in: keeping an active youngster at rest, avoiding a feeling of neglect on the part of the other children because of the attention paid to the sick child, arranging for long-time sanatorium care when funds were limited or free beds unavailable. The welfare workers were all interested in the possibility of a program and felt that it was much needed.

Later when Dr. Davis called his staff together, he presented the general plan for the program and outlined specific clinical and hospital services which could be provided. The hospital to be used was in the local community, easily accessible to children and families. The nurse and nutritionist described services in their professional area which were needed.

Miss Douglas told about the results of her conference with the welfare department as to some of the social problems that might arise. She also discussed the possible emotional implications of rheumatic fever and its treatment for the child, his parents, and his brothers and sisters.

Because of this, it seemed to Miss Douglas, social casework services were essential. Consultation and work with other agencies might also be services needed fairly quickly.

The hospital had no social service department. Miss Douglas wondered if it would be possible for Dr. Davis and herself to work with the hospital toward the development of such a department to provide social services to the children with rheumatic fever as well as to other children. In the meantime because of the need for social casework service, and because the program was to be small, the group decided that she should give these services.

Dr. Davis emphasized that this was preliminary planning and that specific problems and issues would arise as the program got underway. Weekly conferences would be held so that all members of the professional team would have a chance to discuss things together.

Policy making.—All professional staff are concerned with the development of sound policies. These include policies affecting development of agreements with other State agencies, scheduling itinerant clinics reaching the rural areas, selection of children on waiting lists, reports of medical and social data to local communities, payment for transportation and overnight care, eligibility for treatment, educational leave for professional staff, and personnel practices. Naturally the administrator of the agency and the program director carry final authority for determining policies, but the various professional staff members contribute their thinking. In some instances they may assemble information on policies affecting mothers and children for the use of the medical director when changes in policy are being considered.

The medical social workers give particular attention to the social and emotional aspects of care in the consideration of these policies. For example:

In one State, the director of the crippled children's program called together members of his staff to consider the problem of children on the waiting list for admission to hospitals for treatment. How should the children be selected for admission? Should they be taken in order? Should medical urgency be the determining factor? Should other factors be considered?

The group agreed that medical urgency was clearly the most important criterion.

Miss Osborn, the medical social consultant, because of her experience with such situations in the past, raised the question as to what social factors needed to be considered in selecting the children.

She described a situation of an expectant mother with six children of preschool and early school age. Freddie, age 5, was so severely handicapped by poliomyelitis that he was unable to move about without help. The other children often ignored him or were impatient with him as they went about playing. The child, himself, was very unhappy, and the complete burden of his care fell on his young mother, a well-meaning, but worried person. His father worked long hours and was able to offer little help to the mother in her care of Freddie or of the other children.

Miss Osborn pointed out what it might mean to the child, his mother, and the total family group if the recommended surgery was done and was successful. Wasn't it important to admit Freddie as soon as possible even though the medical need was not urgent?

There were other situations similar to this, she said. In a county study of a number of children which she had made recently, some of these had come out clearly. The orthopedic nursing consultant spoke of several other children in similar situations. The physical therapist cited other examples out of her experience.

The group agreed that selection of children from the waiting list should be done on an individual basis with consideration of the family situation and the patient's feelings as well as the medical problem. A plan for regular conferences for this purpose was set up.

Medical social workers are concerned with policies affecting eligibility for service. They work with the medical director and other members of the staff to establish policies based on the recognition that the social and emotional as well as the medical and economic needs of the patient and his family must be considered in determining eligibility. They question the requirements of court action in some States before children are admitted for treatment. Sometimes medical social workers make recommendations concerning the acceptance of individual patients for care on the basis of information obtained through their medical social interviews. Or they give consultation to others who carry this responsibility.

The total professional team also is concerned about the various procedures set up to facilitate care for mothers and children. Often the medical social worker looks at such procedures in terms of what they may mean to individual children and their families. If forms are being set up, he may question including an agreement by the parent to surgery on the child before such treatment has been recommended by the physician. He knows that such agreements often arouse anxiety in parents. He may also raise questions about the use of long and detailed forms that must carry the parents' signature and be notarized, because he knows they may increase parents' apprehension and sometimes even result in a refusal to permit the child to receive care.

Standard setting.—Each member of the team is responsible for standard setting in his own professional field. The medical social worker sets standards for medical social services within these programs, or when indicated, within hospitals and convalescent institutions from which care is purchased. He also works closely with child welfare divisions of State departments of public welfare in the development of standards for foster care of handicapped children. For example:

A rheumatic fever program was set up in one county in a State. The county covers both rural and suburban areas. In the rural area, almost no public transportation exists, and in the suburban area, very little more.

There are few physicians and no medical facilities in the rural section. The suburban area has a great many physicians and one hospital. The program was set up to use the local hospital as well as one in a large city nearby but outside of the county.

In reviewing convalescent needs of the patients, the meagerness of facilities was immediately evident. There were no beds for Negro children under 12; a few beds were available for those 12 to 17. No facilities existed for white children between 12 and 16.

Because the staff of the program realized that this lack would create problems, the county medical social worker discussed with the physician in charge of the program and with the supervising nurse the question of using foster homes for convalescent care. They agreed this should be explored.

The medical social worker then approached the county welfare department. With the permission of the director, the medical social worker consulted the staff member responsible for the foster-care program.

This worker explained the standards developed by the welfare department. The medical social worker wondered whether the health standards for foster homes needed to be strengthened if these homes were to be used for children with rheumatic fever. The child welfare worker agreed readily that this might be so.

Because health standards were the concern of the total health team, the medical social worker met with the medical director, the nurse, and the nutritionist for general discussion of what would be needed in a foster home used for convalescent purposes.

The medical social worker arranged a joint conference of the health and child welfare personnel to discuss the standards of the State welfare department for foster care.

This conference proved to be most useful to both groups of workers. In most respects, the standards of the State welfare department for foster homes were similar to those wanted by the health department. But, when these standards were considered from the point of view of the needs of the child with rheumatic fever, the groups agreed that additional safeguards were necessary.

The responsibility of the various professional personnel came up for consideration in the conference. The public health nurse would help the foster family understand and meet the health needs of the child with rheumatic fever and provide the amount and kind of nursing care he requires. The nutritionist would give some advice

as to how to make food attractive and palatable as well as meeting the nutritional needs of the children. The child welfare worker from the welfare department would continue her usual relationships with the foster parents and family as in all foster home placements. The medical social worker would give consultation to the child welfare worker in respect to the implications of the medical condition in meeting the social needs of the child and his family. The health department would have the responsibility for meeting the child's medical needs.

On the basis of the discussion, the medical social worker and child welfare worker outlined the standards and policies agreed upon. These were accepted by the directors of both the health and welfare departments.

The degree to which the medical social worker can participate in this way depends upon the stage of development of the maternal and child health and crippled children's programs. In an expanding, developing program he has many opportunities to contribute to program planning. If the agency follows the practice of calling staff meetings and securing staff reactions, the medical social worker will have an opportunity to participate in this way. If medical social services have had a tested period in the agency and have demonstrated their effectiveness, the worker will be called upon more often for help in program planning, policy making, and standard setting.

Community planning

The effectiveness of health and medical care is influenced by the availability of other basic health and welfare services and facilities within the community. Professional personnel in these programs are in a position to determine and see at first hand the results of community success or failure in providing the kind and quality of service needed by a mother or child or family. If the standards of financial assistance through public assistance are low, they inevitably affect health and medical planning. If foster homes are not available for handicapped children, often they cannot secure the care they need. If children remain in hospitals too long because good convalescent facilities are not available, they are not being served as they should be.

The major interest of the medical social worker in community planning lies in its social aspects. His objectives in community planning are:

1. To work with social agencies and with community groups in identifying needs and gaps in health and related services to mothers and children.

2. To help these agencies and groups develop new resources

and services to meet health needs and to redirect or expand existing services.

3. To assist in facilitating and promoting coordination of services for mothers and children provided by various community health, education, and social agencies.

The medical social worker brings to this activity his knowledge of the needs of individuals. As a person trained in social work, he is familiar with policies and procedures of social agencies and can communicate to them needs relating to health and medical care. As a member of the health team, he can help his fellow team members by keeping them informed about social resources and how to obtain services. He can contribute much to better working relationships between personnel in health and social agencies by explaining some of the problems and pressures faced by the two kinds of agencies.

A State medical social worker on his first visit to a county health department found the personnel disturbed over strained relationships with the county welfare department. The medical social worker in an effort to find out what the trouble was asked the health officer and the supervising nurse what they thought the difficulties were and the reasons behind them. They said that the welfare staff was uncooperative, hard to work with, and insensitive to the needs of patients.

The health officer said that for more than a year, he had tried without success, to arrange a conference with the director of the welfare department to talk over the situation, but the director was just "too busy." The medical social worker wondered if it would help any if he first talked to the welfare director to find out about the situation. The health officer thought it might, so it was agreed that the medical social worker would try this.

The medical social worker then made an appointment with the county director of welfare and the county child welfare supervisor. He asked whether the welfare department had problems in its relationship to the health department?

Indeed it had—often health services weren't readily available to their clients and their clients didn't get the kind of help and information they needed; sometimes the health department insisted upon sending members of its staff into the homes of clients of the welfare department without apparently having any clear purpose.

The State medical social worker expressed his appreciation of the difficulties created for both agencies in this situation, and perhaps more important, for the clients. What was the basis for such difficulties? Were some of them based on lack of information and misunderstanding?

Did the welfare department know the program of the health department and what this department was trying to do for patients? Did the welfare department always find that the health department understood what the welfare workers were trying to do for families?

The welfare director and child welfare consultant agreed that

these were some of the matters which caused difficulties. Perhaps the staffs of both the health and welfare departments should get together to talk them over. If such a meeting were held, both the State child welfare consultant and the State medical social worker should be present. The medical social worker could discuss the situation further with the State child welfare consultant before the meeting.

The idea of a joint meeting was accepted by the health officer and staff and was quickly arranged. During this meeting many issues were raised by the two departments—and worked out to the satisfaction of both.

As a result of this discussion, a plan was agreed upon which provided for joint staff meetings, joint committees, and a steady interchange of information.

As the plan got underway, both the State medical social worker and the State child welfare consultant helped in working out details of policies and procedures between the two departments. The plan once in operation proved very successful.

The following example shows the medical social worker working with others in identifying a problem needing community planning and in developing a small but valuable service to meet it.

The medical social worker in one State crippled children's program gave social casework service to a group of handicapped children who, except for occasional visits to a clinic, were homebound. In most instances, a teacher came into the home each day. But with the exception of their school work, time hung heavy for these youngsters. In addition, their mothers rarely had the opportunity to leave them, thus encouraging the children's dependency and giving the mothers no outlets.

The medical social worker brought this problem to the attention of the director of the program and the nursing consultant. Both agreed that something needed to be done about this situation.

The medical social worker then went to a local women's organization and discussed the problem with the members in an effort to gain their support.

The members were eager to help. Plans were made for selected women to serve as "sitters" for the mothers, thus making it possible for them to get away from home occasionally. In addition, these women were to carry on recreational activities with the children.

The medical social worker suggested certain criteria for the selection of the women to do this work and a series of orientation meetings were held. The medical director and nursing consultant participated in these meetings to discuss what effect such close confinement had on a child and what could be done to help him. The nursing consultant explained this plan to the public health nurses who were visiting in the homes of these children.

The medical social worker recognized that these homebound children need relationships with other children. For this reason she enlisted the support of the teachers in the schools they had attended. Plans were made for regular letters from other children, some visiting, and even the publication of a "newspaper" for the children to give them a sense of continuing to belong to a group.

In collaboration with the medical director, the medical social worker assumes direct responsibility in community planning related to development of medical social services in a hospital, in a convalescent home, or in the local health department. He stimulates the development of social casework services in the community. He may help to open camping facilities to handicapped children or in the case of children who cannot fit into the usual camp program, he may work to establish special facilities for them.

All of these activities are undertaken *with* the community rather than *for* the community. In the fulfillment of them, again the medical social worker uses many technical processes, moving from one to the other as needed.

Educational activities

Hospitals have long held as one of their major responsibilities the teaching of various professional groups. Health departments and crippled children's agencies are assuming more and more responsibility in this field, too, with medical social workers participating actively in programs of educational institutions and in-service training activities within agencies.

Each member of the professional team carries responsibility for taking part in the education of students in his own professional field. In addition, all professional personnel in these programs have a contribution to make to the education of the various professions represented on the health team. The medical social worker emphasizes the influence of social and emotional factors upon people and the importance of understanding this in helping individuals.

Clearly the objective of such teaching is to bring to another profession an approach and a point of view which they can integrate and use in their own profession; the objective is not to teach social work as such. In the past, the medical social worker has contributed a great deal to the teaching of an understanding of human behavior and motivation. As this content is incorporated into the basic education of other professional groups, the contribution of medical social work can be more specifically focused on human behavior and social relationships which affect health and illness and the ability of individuals to utilize and profit from health services and medical care.

Participation in educational activities in these programs entails considerable flexibility on the part of the medical social worker. He often needs to adapt himself to students with a variety of backgrounds and experience. One week he may meet with public welfare workers and the next, with public health

officers or nurses; the former needing better understanding of health and meaning of illness, the latter needing better understanding of the social implications of illness, social services, and resources.

The content of the medical social worker's participation in educational activities varies depending upon the functions of the agency developing the in-service programs, the educational background and skill of the students. Such activities are planned and carried out jointly by the teacher of the student group and the medical social worker. Ideally the medical social worker's participation should be a continuous venture with an opportunity for follow-up and evaluation.

Studies, surveys, and research

Medical social workers in maternal and child health and crippled children's programs have made small but encouraging beginnings in studies bearing upon the program. For example:

> The medical director of a maternal and child health program reported that the doctors in one community had raised questions regarding the eligibility of some children for child health conferences. He asked the medical social workers to secure the facts about the situation. They analyzed a random sample of clinic records and family folders. They looked for such information as family income, occupation of wage earner, number of children, debts and other obligations in relation to ability to meet current rates of physician's services. Since data in records might be limited or out of date, they also interviewed all the mothers bringing children to these conferences in a selected, specified period.
>
> The findings of this study revealed that very few families could afford private medical care. In submitting their report to the medical director, medical social workers included examples from family situations which made the findings graphic.
>
> The results were carried by the medical director to the local group of doctors who had raised these questions. The doctors agreed that these children were eligible for child health conferences. A plan was set up for on-going discussions of the needs of this group of children.

Other studies have been made of children remaining in hospitals for long periods of time to see what their needs were and if these could be met in their own homes. At the request of administrators in hospitals where there are no social service departments, information has been gathered which has affected discharge policies and procedures.

Medical social workers in these programs have been involved in studies of the needs of certain diagnostic groups of mothers and children. In one State, the social and emotional problems of women with complications of pregnancy have been

analyzed. In another State, a study was made of the problems and types of services needed for cerebral palsied children. Medical social workers studied the social and emotional needs of these children and the services they required.

Though little has been done in the way of intensive research, the need for such research is recognized. For example, there is evidence that social factors contribute to maternal and infant mortality and prematurity but the interrelatedness of medical, nutritional, social and economic factors needs more careful analysis.

Responsibility for administrative activities

In a maternal and child health and crippled children's program, certain activities which may be thought of as administrative have social implications. Arrangements for hospitalization of a patient, for example, may be complicated by fear, anxiety, and other attitudes which make handling this as a purely administrative matter very unwise. When evidence of such complications is present, the help of the medical social worker is desirable. Requests for information from social agencies may require much more than routine handling, offering as they do, an opportunity for interpretation of the medical social aspects of a situation, and potentialities for more effective service to the child. Thus the worker may wish to handle certain selected inquiries himself. Making provision for transportation of a child to the hospital and back to his home again may entail help in developing better resources for this service within the agency or in other community agencies. The medical social worker might well undertake this type of community planning. However, arrangements for individual children could well be handled by other personnel.

Some duties do not seem to have social implications, for example: notifying parents when hospital beds are available and when a patient is discharged from a hospital; making appointments in clinics or physicians' offices and notifying families about them; transmitting medical reports or summarizing medical information. If social problems do arise in any one of these routine procedures, the medical social worker assumes responsibility for handling them.

When the medical director has to delegate responsibility for administrative routines to various professional personnel, medical social workers, of course, do their part. But even as these responsibilities are shared, the total group will want to explore how such duties can be assigned to appropriate personnel.

At all times, all the professional personnel have to recognize that if they carry a large proportion of routine administrative responsibilities not primarily related to their particular area of competence, they may find it impossible or difficult to make their characteristic contribution to the program.

Processes Used by the Medical Social Worker

Many processes are used by the medical social worker in the performance of his functions. Some are specifically social work processes—such as social casework, social group work, and community organization in social work. Some are processes used by other professions as well as by social workers, consultation and teamwork.

Social casework is a way of helping individuals with personal or environmental difficulties which prevent them from functioning to their fullest capacity. It requires an orderly process of study and diagnosis of the social situation, the individual in relation to his situation, and the establishment of a meaningful relationship with him through which he is helped to meet his problems. It is based on a social philosophy, a body of knowledge regarding the meaning of social relationships to the individual, and a skill in the use of self to help people with their social problems. This process is shown in the initial interview with Anne described on p. 12.

Social group work [4] is a way of helping groups to accomplish their purposes and to further the social development of the individuals who compose these groups. It rests on the same basic philosophy and understanding of the individual needs as does social casework but adds to them the understanding of group processes and interaction. It also involves use of self in a professional way to help the group.

Community organization in social work is a way of "helping the community to identify and appreciate social need, to choose a suitable means of filling the need, and to muster its strength to achieve this self-determined goal." [5] It holds the same objective as that of the other processes—to help people deal with the problems of social relationship and adjustment and to find

[4] Gertrude Wilson and Gladys Ryland: Social Group Work Practice: The Creative Use of the Social Process. Boston. Houghton Mifflin Co., 1949, 687 pp.

[5] Kenneth L. Pray: When Is Community Organization Social Work Practice? In Proceedings of the National Conference of Social Work. . . . April 13–19, 1947. New York: Columbia University Press, 1948. p. 194–204.

satisfying relationships—and is based on the same philosophy and knowledge. It also involves the use of self through self-awareness and sensitivity to others in a helping relationship. Some of the process of community planning is illustrated in the examples on p. 26 and 27.

Consultation[6] is just beginning to be analyzed and studied as a process. Through consultation, the consultant uses his own special knowledge to help another worker handle some aspects of his job more effectively. In the field of social work, consultation aims to deepen the understanding of social and emotional factors and their impact on the situation. The social work consultant in turn needs to seek consultation from people in professions other than his own.

Consultation is based for its acceptance upon the "authority of ideas"—not the authority inherent in administration. Consultation, unlike supervision, does not carry administrative responsibility and cannot hold the consultee accountable. It is limited in scope and concerned with specialized aspects of the consultee's job. It is most effective and far-reaching when given to a person in a supervisory position. Through such a person, the effects of consultation may spread in ever-widening circles.

Consultation is more effective if the consultee, out of his own competence, recognizes his need for help and requests it. Sometimes the consultee may seek consultation not because he sees a need for it but because of administrative pressure, or anxiety, or a feeling that this is the thing to do. For him, asking help may actually connote inadequacy.

The consultant, too, is subject to pressures. He may have difficulties in seeing where his help might fit in and how far it can be used by a person with another function and with a different background. He may be insecure as to the extent to which he can reply on the authority of ideas and concerned about the piecemeal nature of the help he sometimes gives. The fact that change often occurs so slowly is likewise a problem he must handle within himself.

In the process of consultation, the consultant builds on the consultee's strength. The creative use of the consultation process makes it necessary to begin where the consultee is—in his thinking and in his feeling. The consultant offers information when this is needed. He gives reassurance, listens sympathetically, shares frustration, eases tensions, suggests new ideas and approaches, and helps to find assets and strengths

[6] We are indebted to Miss Charlotte Towle for many of the ideas included here.

that can be utilized. In addition the consultant generalizes and pulls out principles that can be applied in other situations. The case stories of Jimmie and Mrs. Harris on p. 14 and 17 are examples of consultation given to other professional workers.

The process which integrates and fuses the functions of all professional disciplines is teamwork. Much has been said about teamwork, but all too little analysis has been done in this area. Some of the factors underlying teamwork include:

1. A common understanding of goals as essential to the responsible participation of each member of the total team.

2. The recognition of the interdependence of the various disciplines as essential to productive team relationships. To achieve this sense of interdependence, each member needs an understanding of the uniqueness of the contribution of each member of the professional team and respect for it. Each team member must assume responsibility not only for increasing his own understanding, but for helping the others develop their understanding.

3. An appreciation that teamwork is a continuous process with each member of the team carrying responsibility for maintaining it.

4. A recognition that the success and satisfactions in teamwork are contingent upon the active participation and the ability of each member to utilize the result of these combined efforts. This frequently involves some modification of each individual's own point of view.

5. A realization that the teamwork process is facilitated by the establishment of certain basic procedures.

Because the members of the team are also on the staff of the agency, they are able to make an effective contribution to the program, to each other, and, most important of all, to the patients. In order to maintain and further the teamwork process, the medical social worker has to consistently demonstrate his belief in and acceptance of the teamwork relationship. He has many opportunities to initiate and support teamwork, and it is important that he be alert to them.

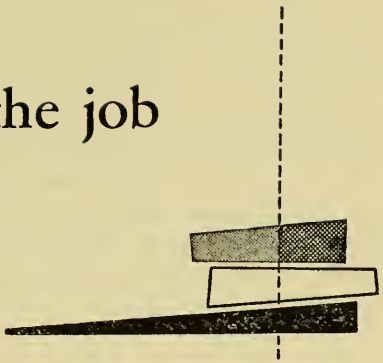
These then are the functions carried by medical social workers in these programs and the processes they use in per-

forming them. Both the functions and processes represent the knowledges and skills of social work applied to one great area of human needs, health. Their application varies with the area of human needs and the setting in which these needs are encountered.

The workers in these programs have responsibility for all the functions discussed and for using all the processes described. They carry these functions in varying combinations and degrees of emphasis. In the performance of the functions, they use one or more processes depending on the situation. How the job, made up of various combinations, has been developed will be considered in the next section.

Medical social workers have come to these programs with a background in social casework but with limited experience with the skills needed in such functions as program planning and community planning and such processes as consultation and teamwork. They have learned much through experience—and experience has proved an excellent teacher. But eventually advanced education will be needed for some of these workers. Those who have struggled and learned the hard way are providing a sturdy base for such education.

experience on the job



Medical social work in maternal and child health and crippled children's programs was necessarily exploratory in the beginning. Sometimes medical social workers employed in these programs were the first such workers in a State. Coming as most of them did from hospitals, they brought to these programs the knowledge and skill gained there, yet the new programs made mandatory many adaptations and new applications. Each worker was forced to decide how he could be most useful and then, on the basis of this judgment, to experiment and evaluate.

As time passed, workers gained security. New workers were no longer the first workers in a program. They could build on what their predecessors had begun. Many carried on a combination of functions essentially like those they had developed in the hospital, placing major emphasis on social casework service, even though the nature of the programs often made it necessary for such service to be concentrated in a brief period of time, usually at certain points of care or in certain areas of a State.

After a few years of medical social practice the workers felt the need to analyze consultation service and its potentialities for the programs. Consultation was a comparatively new activity and it seemed desirable to determine how it could be used most effectively. Because a public program has responsibility to serve all people for whom it is intended, medical social workers wondered whether through consultation their help could be extended to a larger number of people. The medical social work staff of the States and of the Children's Bureau began exploring this idea further, seeking to determine what were the techniques and processes in consultation service. They discussed this in various meetings. They worked with educational institutions in the planning of courses and institutes where consultation could be studied.

For a while, a few workers gave most of their time to consultation, although continuing to carry some responsibility for social casework. The majority, however, continued to place major emphasis on social casework. Finally, accumulated experience made the answer clear. Both methods were essential to an effective program. Consultation service is important, and should be continued, but there is and always will be a need for social casework service in the program, either by State or local workers. This is an essential service for meeting the social and emotional needs of children and their families—for providing a foundation for broader activities.

Ways in Which Medical Social Work Developed

Some of the specific ways in which medical social work developed in the maternal and child health and crippled children's programs can be described. During the experiences over the years many problems have been faced, solutions found, and much learned.

A medical social worker in one State crippled children's program gives a good description of the situation he found on coming into the program and how he attempted to deal with it.

> "In the beginning I found that the medical director and other professional staff members did not have a real understanding of the medical social functions, nor were they too clear as to what help they wanted from me. In the crippled children's clinics I was expected to interview all patients before they left the clinic to explain the medical condition and to be sure the parents understood medical recommendations. Although I questioned the appropriateness of this activity for a medical social worker, I accepted the responsibility for it because some members of the staff felt that these activities were within the scope of a medical social worker's services. Because I lacked experience in working with public health personnel and felt uncertain of the functions of the various members of the staff, I was hesitant and unsure about how to clarify my own functions with the director and staff. By working with the medical director and other professional personnel, activities appropriate to medical social work were gradually defined."

Another worker in looking back over his experience noted the changes that occurred:

> "I emphasized service to individuals through short term casework service in the beginning. Then, because this met the needs of only a limited number of individuals, I changed the emphasis to consultation service to health and welfare workers. Now we have completed the cycle and are increasing our emphasis on short-term casework service.

This seems to have resulted from a recognition on the part of the agency (1) that only through social casework services can the social and emotional needs of many patients be met and (2) that social or welfare agencies often lack a sufficient number of trained workers to give this service."

Another worker traced the proportion of time devoted to each function over a period of 5 years.

"In the beginning, I emphasized social casework service and consultation, and held participation in community planning, program planning, policy making, and educational activities to a minimum. Gradually I decreased emphasis on social casework somewhat and increased the other functions.

"I think among the factors influencing my change in emphasis were the initiation of new services, new responsibilities placed upon the agency, the reorganization of the agency structure, and administrative staff changes. I believe it is necessary to determine whether one function more than another meets the major needs of the program, and whether there are sufficient staff to carry out the particular functions."

Another worker in reviewing the development of medical social work over a period of 5 years said, in outlining "things to do differently another time:"

"I would try to resist engaging in activities with a high administrative content—activities which make medical social functions unclear and result in 'spreading too thin.' I would try to be more selective and follow through more consistently on certain projects in community planning. . . . I would defer participation in in-service education programs of physicians and nurses until I had more knowledge and understanding of the program and more opportunity to do joint planning with them."

Out of experiences such as these certain overall patterns in the development of medical social work have emerged. But a cardinal principle underlying these patterns is that medical social work finds its place in the programs if it has the steady interest and cooperative endeavor of the medical director and staff. The medical social worker plans with them about his own work discussing what the factors are that influence his emphasis and choice among the various medical social functions, the amount of a particular type of service he can give, and where and how he can give it.

In a small State the pattern followed by the medical social worker may be to participate in as many of the clinics as possible throughout the State. These include the crippled children's clinics, the maternity clinics, and the child health conferences. The worker gives social casework services as needed to: children recommended for surgery which is frightening to them and to their parents; children who have to be hospitalized

far from home; children referred for special kinds of appliances, the use of which requires considerable social or emotional adjustment; parents who feel quilty and responsible for their child's congenital deformity; young mothers who are apprehensive over their pregnancy; mothers who handle their babies with tension and anxiety; mothers disturbed about their children's sleeping or eating habits. In instances where medical social services are not available at a medical center or convalescent institution, the worker gives such help. In addition to casework service in clinics, the medical social worker gives insofar as he is able, consultation service to local health and welfare workers concerned with the care of these families.

In a large State, the worker may select a few counties where clinics are held in which both social casework service and consultation can be given. Social casework is a qualitative service, and cannot be effectively given without some limitations in terms of numbers served. This is also true of consultation service. Reasons for the selection of the particular counties to be served are evaluated by the medical director, the medical social worker, and other State staff. They include: The interest and readiness of the county staff for medical social service; the possibility of providing service on a regular and continuing basis; the quality and scope of health and welfare services in the county; and the nature of State-local relations. The restriction of activity to a few counties makes it possible for the medical social worker to know the counties intimately, to know about their resources, their personnel, their ways of work, and how to build on the strengths within each community.

In some States still another pattern may be followed. The medical social worker concentrates on a group of children for whom the medical director and other staff are currently planning or whose problems come to their attention.

Particular groups may be: premature infants, children with rheumatic fever or cerebral palsy, or women with complications of pregnancy. Development of services for these groups means that the medical social worker points out the social problems that may be anticipated and the social services that will be needed throughout the course of care. An example of this type of planning is found on page 21.

Among the problems coming to the attention of the medical director and other staff members may be the children remaining in hospitals for long periods of time. In such instances the medical social worker evaluates home conditions and community resources to determine whether services needed by these children

can be satisfactorily provided. On the basis of such findings, adequate discharge planning is facilitated.

Although in all these various patterns, the medical social worker chooses services to individuals provided either directly or through consultation, nevertheless he keeps the other functions in mind and develops or initiates them as he gets an opportunity. As he develops these services the worker gathers information to be used in program planning and policy making. As he works, he accumulates examples to demonstrate the need for community planning. As he gives social casework to mothers and children and gains experience in community planning, he gathers vivid illustrations to enrich his teaching. Gradually he is able to carry out all the functions with the emphasis changing in accordance with needs in the programs.

In general when the need for additional medical social services has been recognized by the medical director and staff following demonstration by one or more of these methods, the worker recommends the setting up of other medical social positions on the State or district level, in special projects, and in local health departments. He considers with the medical director and other staff where and how the services of additional medical social staff can be used most effectively. As staff expands, one worker is usually chosen to head the group. This chief worker or a supervisor gives technical supervision to the medical social staff.

When medical social services develop at the local level in the health departments of a city, county, group of counties—the seeming direction of the future—and the program decentralizes its services, the State medical social workers function in a consultative capacity. They keep county medical social workers abreast with policies and ideas developed at the State level and secure their thinking and reactions to them. They, in turn, learn about the medical social problems at the local level and call them to the attention of responsible people in the State office. Because they have the opportunity of learning how situations arising in various communities have been met, they are able to make this information available from county to county. From county workers they learn how agreements with other State agencies, such as the welfare and education departments and vocational rehabilitation agency, are working out on the local level and if any changes need to be considered.

Medical social workers in these programs may be called upon for help by directors of other divisions in the health department. Sometimes these workers are asked to offer suggestions on program planning or to help with problems of patients. Although they may not be able to give social casework service to

individuals because of the responsibilities they carry, they do give consultation service. As requested, they help in the development of medical social positions in these other programs. When medical social services develop in other divisions, sometimes State health departments establish a social work section to give generalized services to all the programs.

In undertaking the complex activities characteristic of these programs, the medical social worker must explore and analyze the job to be done, make decisions on the emphasis to be given to the different functions, and constantly evaluate his activities in order to achieve a proper balance.

Factors Influencing Medical Social Work

Some of these factors grow out of the nature of the programs. Some arise because of situations in communities or in States. Some are brought about because of the inadequate number of trained workers in the programs. Some others reflect differences in the workers' experience, interest and approach.

Scope of the maternal and child health and crippled children's programs.—The crippled children's program and the medical care projects of the maternal and child health program, necessarily include a variety of services that are an essential part of medical care. In these, medical social workers demonstrate readily the value of their services. In maternal and child health programs which are primarily educational in approach, medical social workers find it more difficult to determine what their emphasis among functions should be. As workers gain more experience in the preventive aspects of health, they are better able to make choices among functions.

The organization of the program.—Workers employed in a centralized program which operates services directly make somewhat different choices from workers employed in a decentralized program. When programs are decentralized, workers are more dependent upon the establishment of sound working relationships with the local administrative agency.

New needs and new services.—In the course of events, few of the programs remain stationary. Some State health departments joined with hospitals and medical schools in developing community services for the care of premature babies. In order to reduce complications of pregnancy, which cause many premature births, some States gave greater emphasis to prenatal care and to planning for medical and hospital care for women with

complications of pregnancy. A new program, such as the Emergency Maternity and Infant Care program, came into existence during World War II. In many States, services in the crippled children's program were expanded to include children with rheumatic fever. In a few States, children with such handicaps as hearing impairment or epilepsy are being added. Increased demand for well qualified public health personnel is creating pressure on the programs for the training of personnel.

As a result of such developments professional personnel including medical social workers make certain choices. They decide whether new developments in their early stages offer such important opportunities for participation in program planning, policy making, and standard setting that concentrated attention on them is warranted. Frequently they curtail regular on-going activities temporarily to meet the demands of new situations.

The availability of community social services.—The existence or non-existence of other social services affects emphasis in many programs. When no social casework resources are available in a community, medical social workers are forced to handle social problems which might otherwise be referred to a community social agency. At the same time, they work with communities in recognizing the need for and planning for child welfare services and other social services. When State agencies purchase care from hospitals without social service departments, medical social workers sometimes temporarily provide this service for mothers and children. But even as they do so, they interpret the need for social service and demonstrate its value to hospital authorities.

The development of medical social services.—The emphasis among functions is also affected by the number of medical social workers in relation to the size of the group served and the geographic area to be covered, the placement of the worker, his function as viewed by other professional personnel, his predecessors, his skill, interest, and timing.

The lone worker in a State has more difficulty in establishing priorities for service than when there are several social workers on the staff. The lone worker in a large sparsely populated State may have less difficulty in establishing priorities in service than the lone worker in a heavily populated State. Emphasis among functions is also affected by whether workers are on the State or district staff or in a local health department.

Since the medical social worker works as part of a team, what other workers on the team understand and expect of social work influences where and how he begins and how he continues.

When new personnel is added to the team, or there is a gap in medical social services, time must be spent on interpretation.

The emphasis by the predecessor of a worker often affects where he begins. Work that has been soundly built makes a firm foundation for the next worker's contribution. On the other hand patterns well conceived at one period of time may later prove unsound and out of tune with current developments.

The skill and interests of the medical social worker affects his choice of functions. Some are more secure and interested in social casework services than in consultation. Other workers are more skillful in community planning than in educational activities.

Workers must be sensitive to timing, to see that what is a valid emphasis during the early days of a program may be questionable later. They weigh requests for many activities, including some they question. They consider whether acceptance of a particular activity at the present time would further their participation and increase their usefulness at a later date. Through experience, workers learn to balance long-range objectives against immediate objectives.

Medical social work in maternal and child health and crippled children's programs has grown to the point where all but five States have medical social workers in one or both programs.

Through the years medical social workers in these programs have pooled their thinking and discussed mutual problems. The consultation service of the Children's Bureau has made possible the exchange of ideas between Bureau and State and from State to State. Every year at the National Conference of Social Work, State medical social workers meet together to discuss subjects of mutual interest. A subcommittee of the American Association of Medical Social Workers has completed a study of medical social activities in some public health, welfare, and vocational rehabilitation programs—a study that sets a base for further analysis of practice. A bench mark in the steady progress of medical social work in public health was made in August 1950. At that time the American Public Health Association issued a statement on ***Educational Qualifications of Medical Social Workers in Public Health Programs,***[7] which was prepared by their

[7] Educational Qualifications of Medical Social Workers in Public Health Programs. American Public Health Association, Committee on Professional Education in cooperation with American Association of Medical Social Workers. Amer. J. Public Health, 40 (No. 8); 993–999, August 1950. (Reprinted by the Children's Bureau, U. S. Department of Health, Education, and Welfare)

committee on professional education in cooperation with a committee of the American Association of Medical Social Workers.

The development of medical social work in these programs has highlighted the need for greater understanding of public health by social workers and for strengthening the curriculum of schools of social work with respect to material from the public health field.

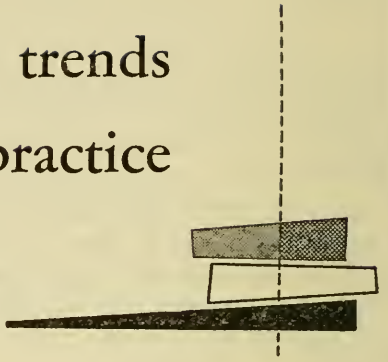
In 1948, the Illinois crippled children's program with a grant from the Children's Bureau offered a special institute for all the medical social instructors in schools of social work to bring them up to date on current principles, goals, and practice of medical social work in maternal and child health and crippled children's programs.

A special impetus was given to the preparation of medical social workers for these programs through the development of three medical social training projects financed through Children's Bureau special project funds. These projects were developed by (1) Louisiana State Health Department, cooperating with the Tulane University School of Social Work, (2) Illinois Division of Services for Crippled Children with the University of Chicago School of Social Service Administration, (3) Massachusetts State Department of Public Health cooperating with the Simmons College School of Social Work, Boston University School of Social Work, and Boston College School of Social Work.

These projects provide students with an opportunity to secure supervised field work placement in health departments and official crippled children's agencies. In addition, medical social supervisors in the projects are able to participate in classroom instruction.

Throughout this section the focus has been on the present role of medical social work in the maternal and child health and crippled children's programs. But though looking at today we have also tried to see the direction and movement of the future. What will be is, of course, affected by the trends outside as well as within medical social work in these programs—trends in public health, medicine, and social work.

present trends and future practice



No profession is an island. The trends that influence it, the currents that shape its future have their origin within and outside the boundaries of the profession itself. Sometimes forces within the profession fix its course; sometimes those outside give it direction; often those within and without combine to chart its way.

This is as true for medical social work as it is for other professions—and it is the purpose of this section to discover some of the trends that are influencing—and will continue to influence—medical social work. Some of them have their origin in public health, some come from medicine, some from social work. Together and in various combinations, they help determine the sweep into the future.

One trend affecting medical social work is the growing recognition on the part of the people of the United States that government can serve as an instrument for safeguarding the health and welfare of the people. With the passage of the Social Security Act, the principle was established that the Federal government shares with State and local governments the responsibility for providing for health and welfare services to mothers and children.

In public health and medicine, a variety of efforts to carry out this broad concept of responsibility are underway. The maternal and child health and crippled children's programs themselves are examples of this. Both public health agencies and hospitals are working more and more closely with each other and with the community. Home care programs are being developed. Services are being made available in remote areas by the establishment of regional plans for hospital and medical care. Tremendous efforts are underway to establish local health departments in

all areas of our country. Cooperative relationships between health, welfare, and educational agencies are receiving greater emphasis.

Another trend is the growing recognition in public health and in medicine of the wholeness of the human organism. Psychosocial factors are seen as having a direct bearing on the maintenance of health and the onset of illness. Illness in turn creates social, emotional, and mental stress. This has implications in planning services for people. It must be taken into consideration in deciding what is to be included in these services given directly to individuals by members of the health team.

This concept of the human being as not only a physical organism but as an individual personality with social relationships inevitably leads to increased emphasis on the social services needed to help people deal with those social and emotional factors affecting health and illness. All health professions are concerned with this concept in the service they give to people. The medical social worker whose training has been concentrated on understanding the social and emotional aspects of human behavior which affect the individual in sickness and in health, has a major responsibility in this respect. This responsibility makes it imperative for medical social work to define clearly what its specific and distinct contribution is.

Another trend of major significance in public health and medicine is the remarkable growth of teamwork. In maternal and child health and crippled children's programs, the skills of many disciplines are required in meeting the needs of children and their families. Teamwork has grown up in these programs in response to this demand.

Teamwork is now recognized as a process—a way of working—in the use of which all professions in the health team need to have skill. How can each profession contribute most constructively to its advancement? All the professions in the health team, including medical social work, should examine the basic elements in this process. All must clarify their particular role and contribution.

The field of public health has always emphasized a preventive and positive approach to health. Through the years public health has enlarged its preventive approach to the point that it not only encompasses people in the mass but people as individuals. As part of understanding the individual and helping him, emphasis has been placed on teaching child growth and development to all workers in the health team. In a number of medical centers training in concepts and methods of preventive psychiatry in mother and child care has also been offered.

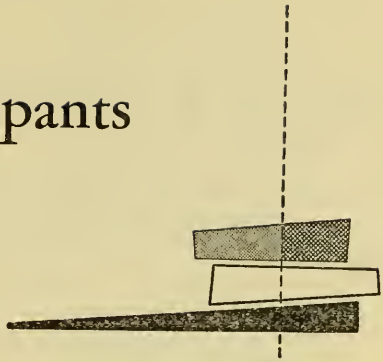
Here again is a trend that has great meaning for medical social work. Medical social workers in maternal and child health and crippled children's programs are offering some services of a preventive nature when the early symptoms of social and emotional strain appear. This represents a real departure since in the past, social work has been primarily concerned with treatment after social breakdown has occured. These preventive services need to be studied, strengthened, and expanded.

Certain trends in social work are also having an important influence. Social work is growing steadily toward greater unity as a profession. It is developing a broader concept of its responsibilities and functions. It is examining its practice, and seeing common elements in various fields of practice. It is analyzing its teaching and studying how it can do a better job of preparing workers. Medical social work in maternal and child health and crippled children's programs will inevitably benefit from this forward movement in social work.

Medical social work, in turn, can contribute to this forward movement in social work by further analyzing practice in health agencies and by identifying the common elements in these settings. On the basis of this kind of analysis of practice, the type of preparation for these positions and the desirability of advanced study beyond the two years of professional education can be determined.

A developing profession in a developing field must experiment and study. Out of such experimentation and study will come growth in practice and, in turn, better service to people.

list of participants



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